Communicable Disease Control under Health Care Reform: “The Perfect Storm”

DHMH TB Control and Prevention Annual Update
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Outline

- Briefly review HCR and how it impacts funding for communicable disease control
- Identify concerns about communicable disease control under HCR
- Evidence-based medicine and public health
- Next steps

TB Reminder

- TB is essentially a disease of the poor [1]
  - Roughly 1/3 of the world's population is infected with TB
  - But low and lower middle income countries account for 90% of new cases
  - And low income countries account for 65% of TB cases and 71% of TB deaths
- TB produces a vicious cycle of poverty
  - Begins with poor households and poor nations
  - Average TB patient loses 3-4 months work; lost earnings can total 30% average annual income
  - Overall this reduces a country's labor force and GDP
  - 10 million orphaned children due to TB (2010)

1 Stop TB. What is the relationship between TB and poverty? World TB Day, March 2002

TB Roadmap: 2000 I.O.M. Report 1

- Maintain TB control
- Accelerate the decline of TB
- Develop new tools
- Increased global U.S. actions
- Assess the impact of this report

1 Institute of Medicine, *Committee on the Elimination of Tuberculosis in the United States*. *Ending Neglect: The Elimination of Tuberculosis in the United States 2000*

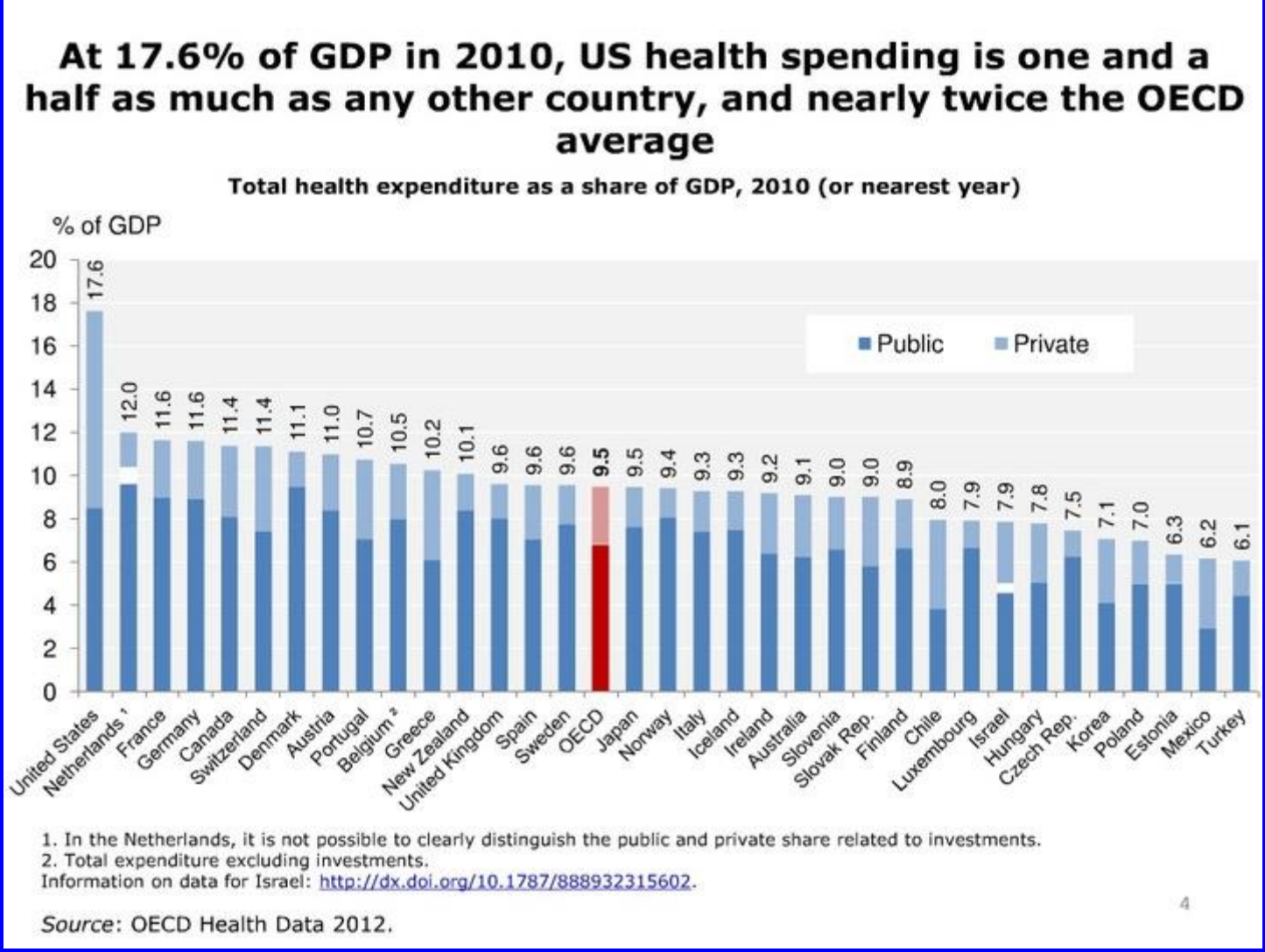
What does communicable disease funding look like at BCHD

- Ryan White: HIV Care
  - Clinical care; support services
- STD Clinical services
- CDC: HIV Prevention
  - Prevention with Positives
    - Linkage to care
    - Partner services
  - Condom Distribution; Policy; Social marketing
- Community Harm Reduction
  - Syringe exchange; Staying Alive; Wound care
- Tuberculosis

What's the impact of HCR on communicable disease funding locally

- History of flat federal funding and cuts
  - STD
  - TB
- Recent trends in federal "sequestration"
  - Ryan White (partial funding)
  - STD prevention
  - Reduction in direct assignees
- Affordable Care Act
  - Expanded coverage and patient protections
  - But expanded coverage does not…..
  - ACA DOES NOT MEAN UNIVERSAL HEALTH CARE COVERAGE

ACA goal: Control health care spending



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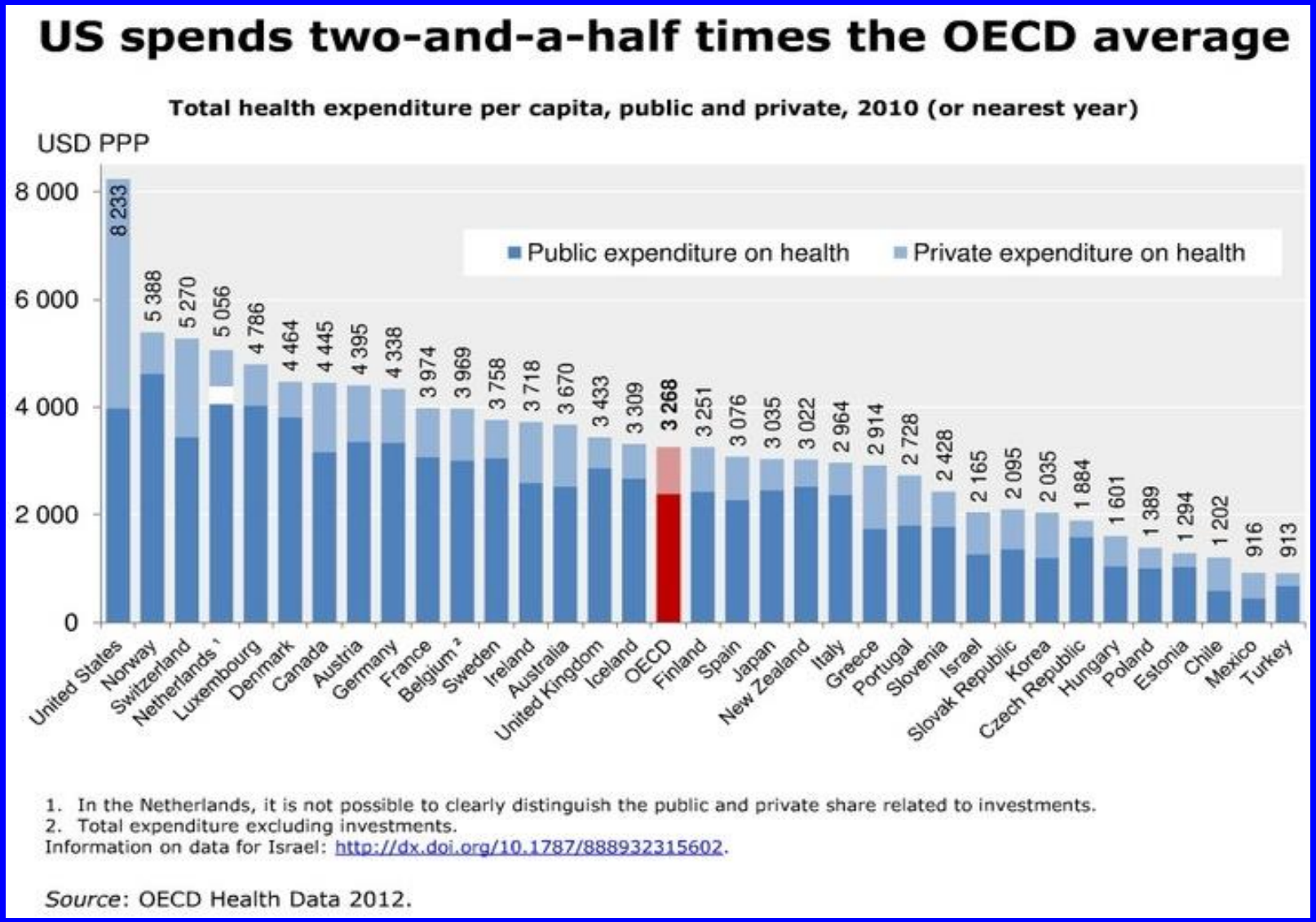


Coverage concerns under HCR

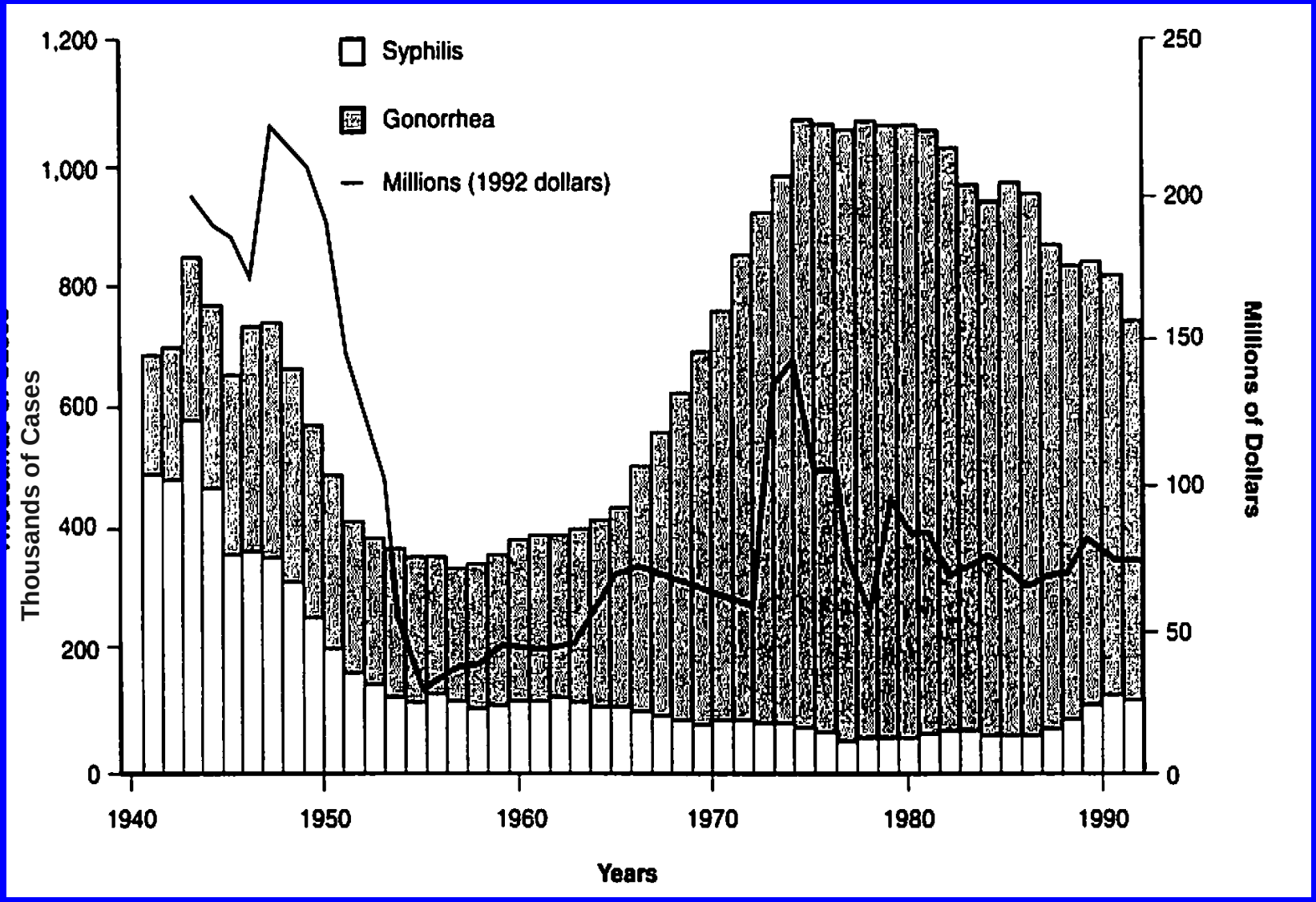
- Assumptions:
  - Everyone will have coverage
  - What about access
  - What about quality
  - Expanded coverage means payment for private sector treatment of TB, HIV, and STDs
  - Will this justify further federal cuts in categorical programs to avoid double coverage
  - “Brown’s Law”

Brown's Law

No public health effort in modern times demonstrates more dramatically than the control of syphilis the results of failure to follow through on a successful program, the results of reliance on 'miracle' drugs rather than on case finding and proven public health practices, and the results of overhasty budget reductions…*Past experience with premature reductions in budgets has been followed by increases in cases and must be avoided.*

William Brown, MD, Chief of the Venereal Disease Control Division CDC, 1961

Brown's Law graphically



Chaulk CP, Zenilman J. Sexually transmitted disease control in the era of managed care: "Magic Bullet" of "Shadow on the Land" J Public Health Management Practice, 1997; 3(2): 61-78.

Quality concerns under HCR

- Providing clinically effective care in the private sector
  - Clinician training in STD/HIV/TB diagnosis and treatment
  - Medical education training gaps
  - Medical errors in private sector care for TB/HIV/STD
    - BCHD TB Program versus private sector 1
    - Errors:
      - Inappropriate initial regimens (too few or wrong combinations)
      - Inadequate dosing
      - Inadequate length of therapy
      - Findings:
        - » 3% versus 38%
      - Similar findings in New Jersey
      - Iseman study 2
- Provide culturally effective care in the private sector

1 Rao et. Al.. Errors in the treatment of tuberculosis in Baltimore. *Chest* 2000; 117.3.734

2 Mahmoudi A, Iseman MD, Pitfalls in the care of patients with tuberculosis: common errors and their association with the acquisition Of drug resistance. *JAMA* 1993; 270:65-68.

Culturally effective care
Case study: LTBI and the foreign-born in Seattle

Seattle Cultural Case Managers

- Recruit and train community residents to:
  - Help create effective messages and education strategies
  - Serve as TB field workers and case managers
  - Conduct extensive neighborhood outreach to:
    - Recruit residents for TB testing and therapy
    - Assist with clinic visits, home delivery of medications
    - Conduct at least monthly house calls, twice-a-week phone calls
    - Establish social networks, assist with other needs

Program Performance Measures

Therapy acceptance rates
Treatment completion rates
Referrals for other social services

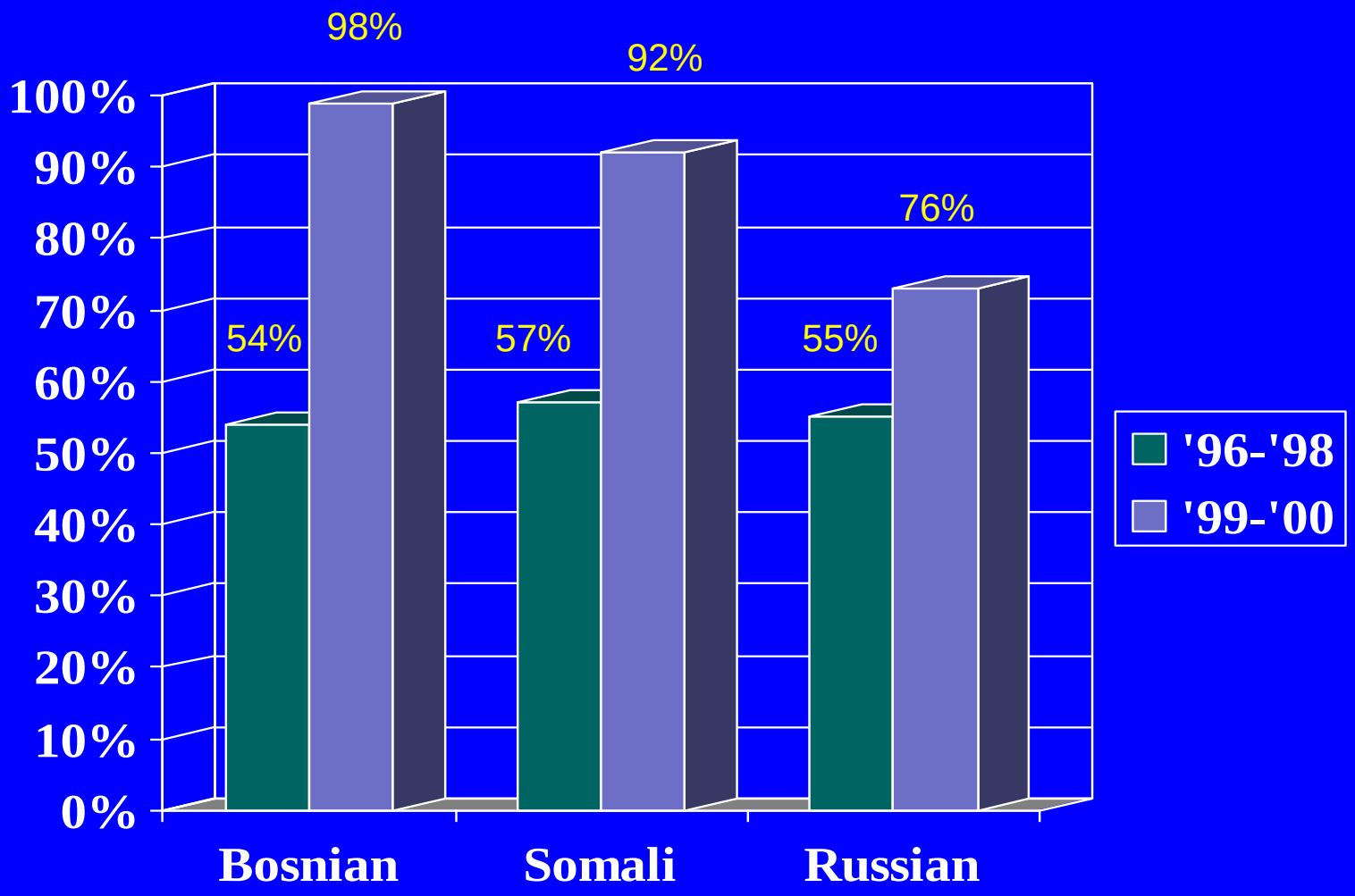
Seattle's Cultural Case Managers Program 1

2,194 immigrants tested 1999 - 2000
442 offered treatment
389 (88%) started on treatment
319 (82%) completed 6-9 month regimen
(vs.60% nationally, 37% Seattle)
93% of client encounters also involved discussions about housing, ESL, mental and physical health, employment and employment training, child care, transportation .

1 Cultural case managers in the treatment of latent tuberculosis in the foreign born. *Int J Tub & Lung Dis* 2004;8:76-82 .

Therapy acceptance rates (’96-’98 vs. ’99-’00)

N= 389 (88%)



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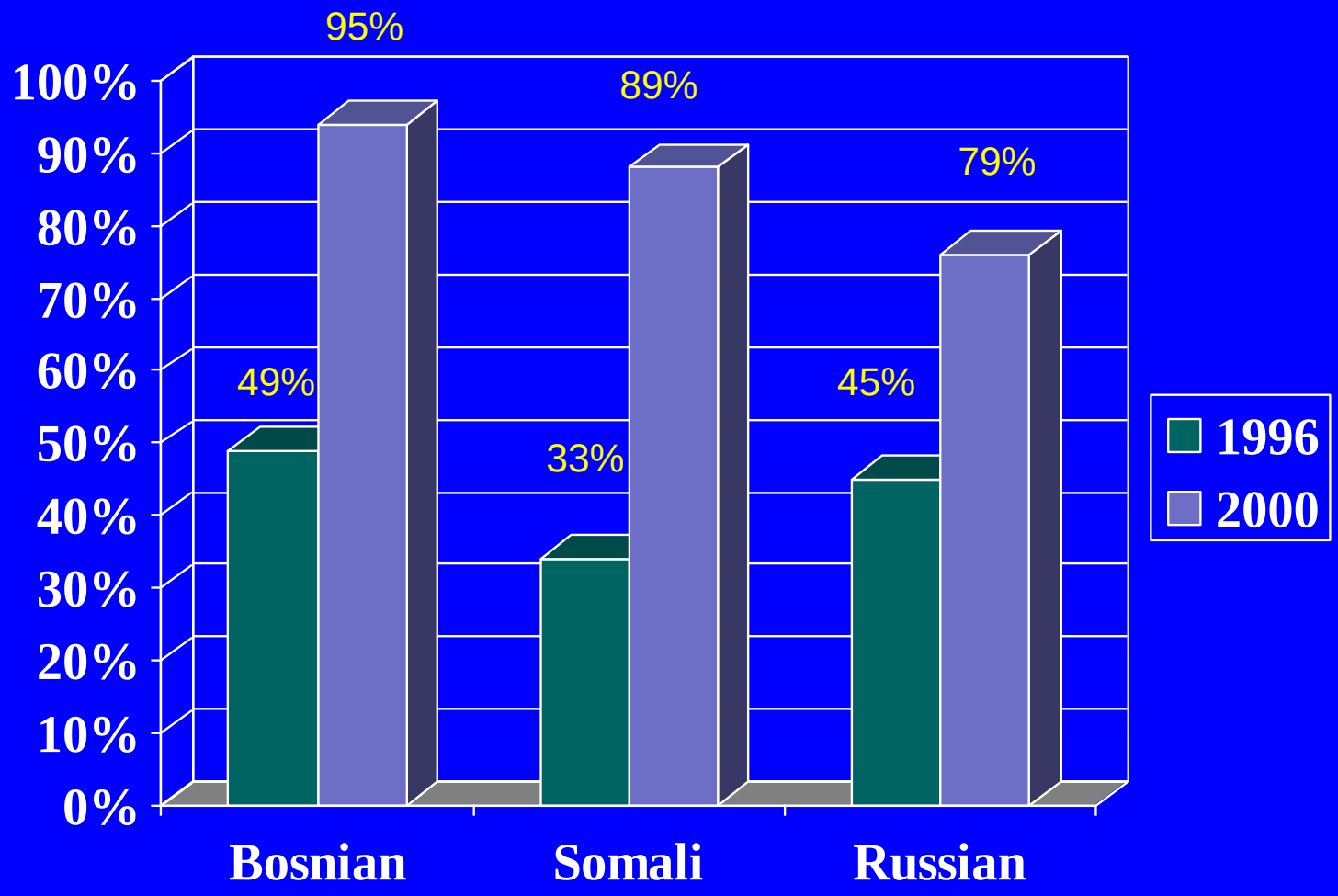
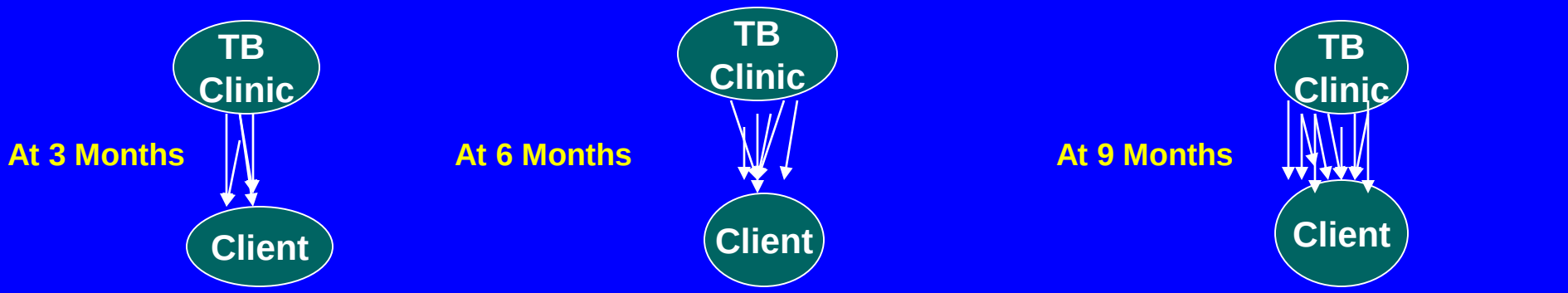
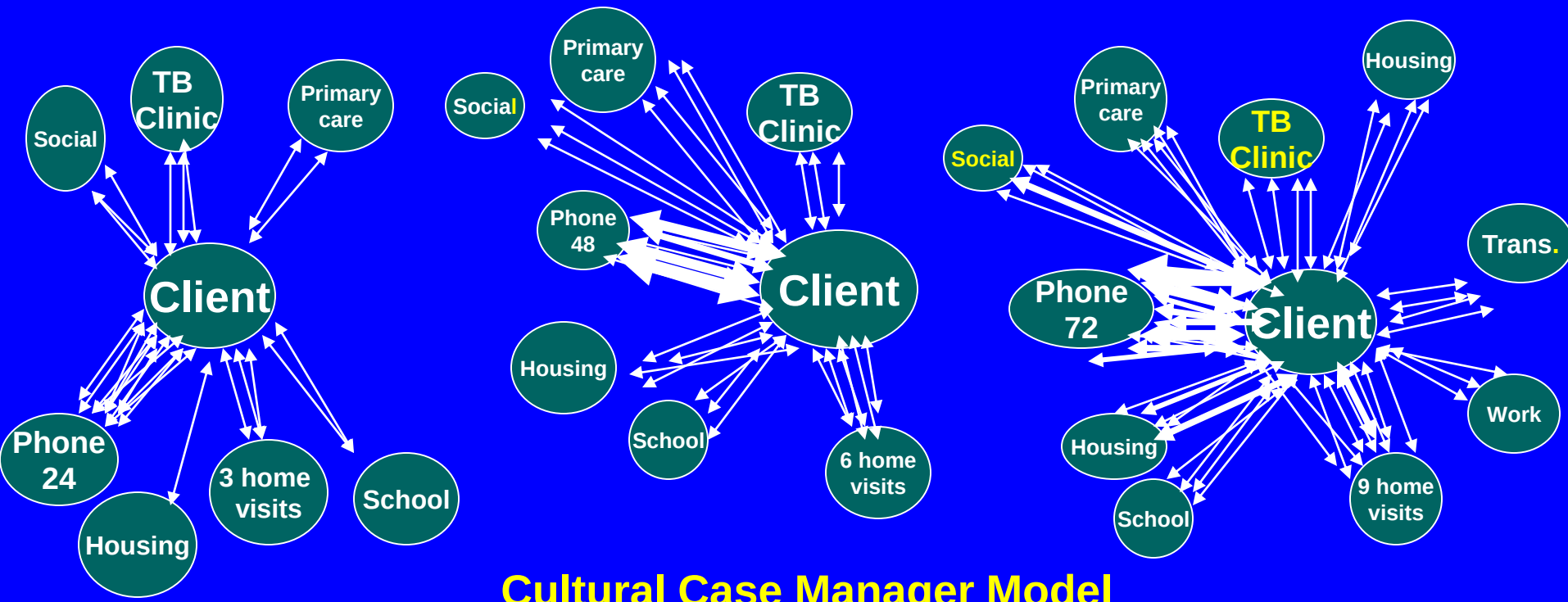


Social Networks



Traditional TB Clinic Model



Cultural Case Manager Model

Characteristics of Effective CCMs

- Knowledge:
  - Of refugee language beyond mere translation: refugee cultures, customs, beliefs, gender roles, family structure. Creates credible messages.
- Experience:
  - With history of effectively serving the target refugee community. Creates relationships.
- Social standing:
  - Highly regarded in the target refugee community: just “being from the community” is necessary but not sufficient. Creates trusted messengers.
- Capacity:
  - Belief in and ability to explain U.S. medical strategies and its complex health care system. Creates effective education.

Insurance Model Limitations

- Core public health functions not necessarily covered
  - Contact investigation
  - Partner services
  - Disease surveillance
  - No supervised care or outreach
  - Wait times for care common
  - Not designed for population-based screening/care
  - Little population-based communicable disease focus

Other challenges for LHDs under HCR

- Capacity Challenges
  - Credentialing
  - Billing
  - Establishing quality management systems
  - Providing care that is outside LHD scope
  - Staff training
  - Providing capacity building to CBOs
  - Creating collaborative arrangements

Baltimore's ranking for TB among major U.S. cities: 1958 - 1992

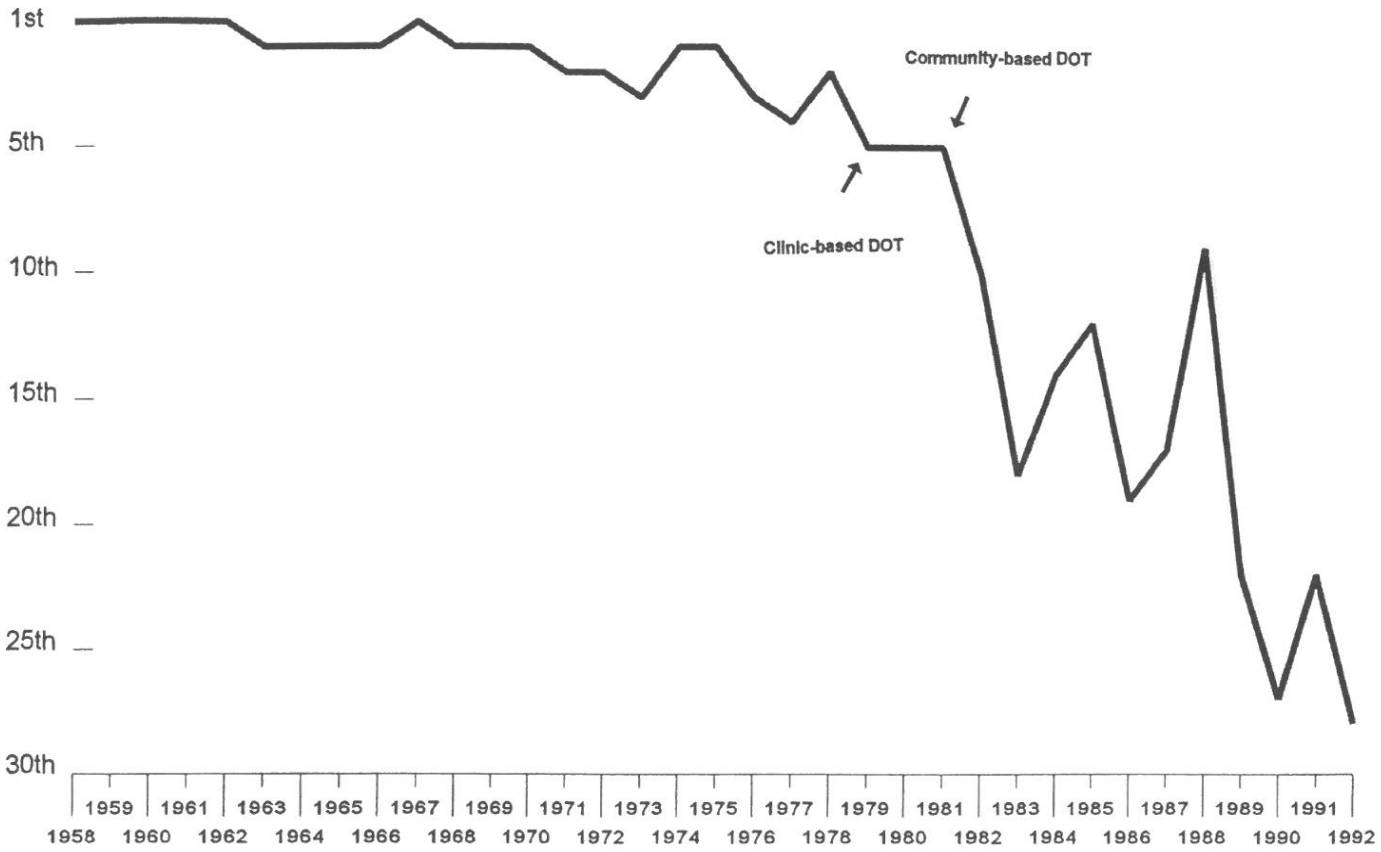
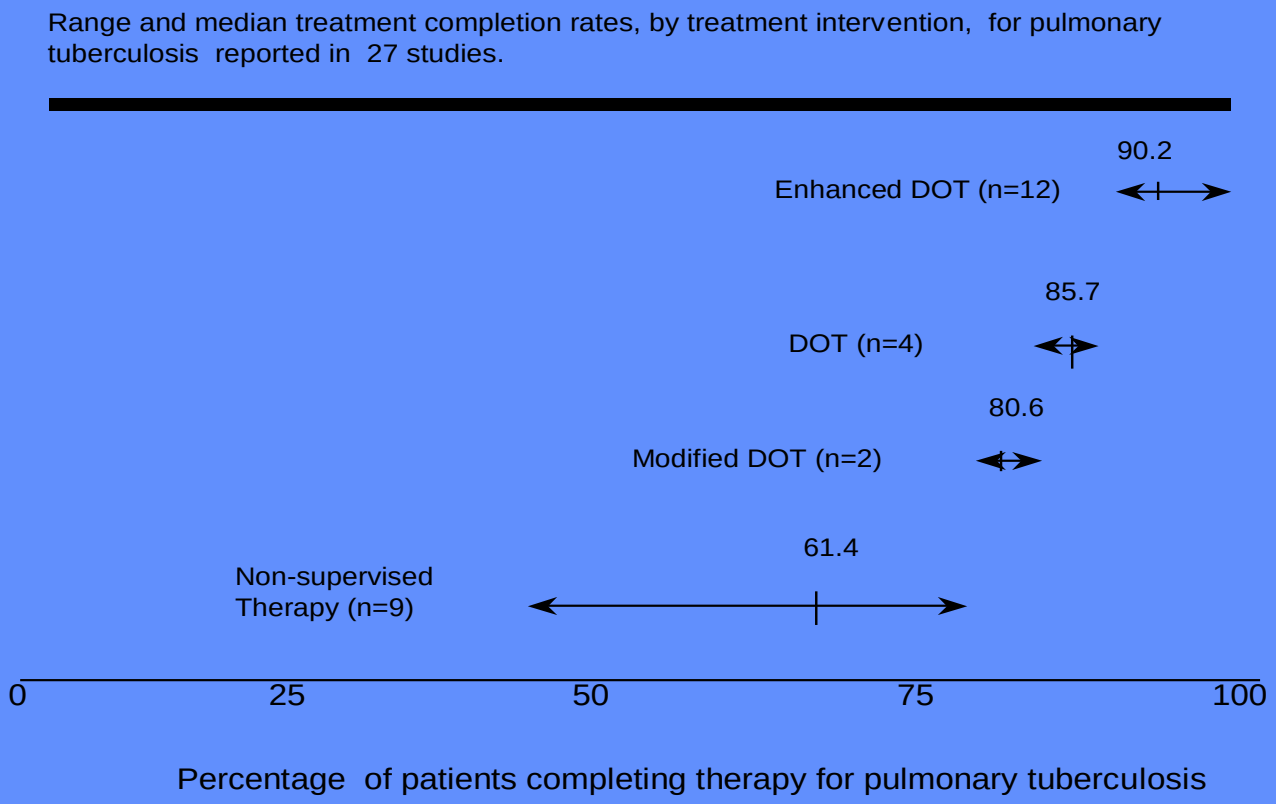


Figure 1 Baltimore's ranking for tuberculosis incidence among all US cities with over 250 000 residents between 1958 and 1992.

Evidence-based medicine and public



Chaulk, Kazandjian, JAMA 1998;279:943-948

Evidentiary Concerns: USPSTF RCT standard and public health

- Theory of Change 1
- Modelling 2
- Anthropological and sociological tools
  - Focus group analyses, social network analyses
- Syndemic relational analyses 3
- Community-based participatory research

1. Change is here. Available at: http://www/theoryofchange.org.

2. Chaulk CP, Grady M. Evaluating tuberculosis control programs: strategies, tools and models. *Int J Tuberc Lung Dis*. 2000;4(supp):S55-S66.

3 Singer M. A dose of drugs, a touch of violence, a case of AIDS: conceptualizing the SAVA syndemic. *Free Inquiry*. 1996;24:99-110

Other communicable disease control concerns under HCR

- How to:
  - care for adolescents, especially STIs
  - care for immigrant minority populations
  - ensure access STD/HIV/TB specialists
  - use MIS for better surveillance
  - reduce high voluntary disenrollment
  - improve on low consumer satisfaction
  - overcome diagnostic challenges (TB, syphilis)
  - address confidentiality concerns (EOB)
  - Improve client and community outreach
  - provide effective counseling

Strategies to improve communicable disease under HCR

- Subcontract with PH specialists
  - Public health clinics: TB, STI, HIV,
  - School-based clinics
  - Community and migrant health centers
  - Hire HIV/TB/STI specialists
- Require CME credits in TB/HIV/STI
- Strengthen MIS review
  - Immunization rates, screening rates, UPSTF guidelines adherence, identify preventable hospitalizations/ED visits
- Medical record audits

Next Steps

- Develop a body of evidence on what's effective:
  - Identify current best practices, programs, interventions
    - Theory of change: qualitative + quantitative methods
  - Refine asset mapping
    - All communities have some assets
    - Residents, existing capacity, CBOs/NGOs
  - Develop, refine and field test new models
    - Public private partnerships
  - Provide customized technical assistance
    - Peer-to-peer approaches
  - Clear channels of communication between management and front line staff